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OSU CENTER FOR HEALTH SCIENCES UNVEILS NEW FACILITY

Oklahoma’s largest state-of-the-art medical simulation teaching center, The A.R. and Marylouise Tandy Medical Academic Building, features high-tech, computer-programmed simulation manikins to teach medical students.

2017 AOA HOUSE OF DELEGATES REPORT

The American Osteopathic Association (AOA) convened for the 2017 House of Delegates at the Chicago Marriott Magnificent Mile Hotel July 21-23, 2017. Read all the details of the annual meeting along with the accomplishments of the Oklahoma delegation.

MALNUTRITION AND THE PHYSICIAN

Written to osteopathic physicians offer explanation and guidance on malnutrition, this article by Capt. Joshua S. da Silva, D.O., was awarded second place in the 2017 POMA Clinical Writing Contest.
26  LEGISLATIVE UPDATE

Read the OOA’s response to the Supreme Court’s ruling on Senate Bill 845 along with a summary of the 2017 senate bills which impact health care.

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Question: Who would have thought that placing an additional tax of $1.50 on a pack of cigarettes and calling it a fee would have been considered unconstitutional?

Answer: Almost everyone. In fact, the state legislature called it a tax all the way up until they couldn’t afford to anymore. The Oklahoma Constitution specifically states that new taxes must originate in the house, must pass by a super majority (75%) in both houses and cannot be voted on in the last 5 days of a regular legislative session. Since that wasn’t possible, legislative leaders decided they would simply call the tax a fee thereby allowing the bill to originate in the senate, pass by a simple majority and do it on the last day of the session. On August 10, the Oklahoma Supreme Court unanimously declared the fee a revenue raising measure and therefore a tax, and consequently unconstitutional. To simply call something that it’s clearly not in order to balance the budget is tantamount to counterfeiting. It is insincere and irresponsible.

But what’s done is done, and we must move on from here. The mission of the Oklahoma Osteopathic Association is to “Advocate for the Osteopathic Profession and Promote the Health and Well-being of all Oklahomans”. The failure of this measure impacts Oklahoman’s health on two fronts. The increased cost of cigarettes would have been a significant deterrent to buying them, especially by young people resulting in fewer smoking deaths and ailments. Secondly, the revenue lost is estimated to be $215 million. Of that amount, the Oklahoma Health Care Authority (OHCA) would have received $70 million or 7% of its budget. Besides impacting nursing homes and rural hospitals, OHCA provides funding for physician Medicaid payments. Those payments were cut by 3.25% in 2010, 7.75% in 2015 and 3% in 2016. In March of this year, OHCA reported it would need $69 million new dollars to avoid further cuts of up to 8%. It stands to reason that fewer and fewer providers will treat Medicaid patients as the reimbursement rate falls which will lead to even further problems with access to care. The Department of Mental Health and Substance Abuse Services (ODMHSAS) would have received $75 million or about 23% of its total budget had...
this measure been properly passed. The impact of this on police, emergency rooms, prisons and the opiate crises is obvious. The Department of Human Services (DHS) would have received $69 million or 10% of its budget of the inappropriately appropriated funds. DHS had already been cut by $29 million for the previous fiscal year. Loss of further funds will impact the elderly, child care for low-income families and people with disabilities. All of this does not even consider the $304 million in potential matching federal funds which will be lost. That brings the total loss to a whopping $519 million!

Fortunately, the smoking rate in Oklahoma has decreased since 2015 thanks to grants and programs through the Tobacco Settlement Endowment Trust (TSET). Adult smokers in the state have decreased to 19.6% from 22.1% of the state population raising Oklahoma’s rank from 45th to 36th. The national average is 17.1%. This is a significant improvement and we must continue that trend. Remember that big tobacco is ever vigilant in getting young people to start and continue smoking. In Oklahoma, over a quarter of individuals between the ages of 25 and 34 still smoke. An additional tax of $1.50 per pack would have been a tremendous smoking deterrent for this group. About 7,500 Oklahomans die each year from tobacco-related causes, and of those, 700 die due to secondhand smoke. Amazingly, the annual health care cost to Oklahoma from smoking related causes is over 1.5 billion dollars. Of that amount, over 2.5 million dollars is paid for by Medicaid. The estimated tax burden to each Oklahoma household due to smoking is about $900 dollars and the loss of productivity due to smoking in Oklahoma is estimated to be 2.1 billion dollars per year. These numbers have improved since the smoking rate has decreased, but still remain quite high.

Governor Fallin has called a special legislative session to make up for the $215 million deficit and concomitant loss of federal matching funds. Legislative leaders say they are putting a plan together. For the sake of the health and well-being of all Oklahomans, legislators must act responsibly and with Oklahoma citizens in mind. One’s own aspirations must be put aside for the benefit of the whole. Petty politics have no place in such serious matters as life and death. I’m the first to admit that I’m not a politician, and I’m sure many readers consider me naïve. But what I am is a concerned physician who’s tired of seeing my state ranked in the lower 40s in health care year after year; who feels that physicians need to take some accountability for that ranking and offer our service and expertise to government agencies that impact health in Oklahoma. I am a concerned physician who believes that we can put enough pressure on our legislators and governor to develop an enduring plan for the health of our people. I also happen to be president of the Oklahoma Osteopathic Association, an association that is well respected and whose dual concerns are for the Osteopathic profession in this state and the health and well-being of all Oklahomans. As such, I am asking osteopathic students and physicians to join with me in improving health care in our state. More details on how we might do this are in forthcoming reports. The governor has called a special legislative session. I implore you to use any influence you have to persuade legislators to pass a measure or measures that provide a long term fiscal solution that assures improved health to our patients.

Just prior to submitting this, I was informed that, Beverly Mathis, DO, my partner and friend for the last 31 years died peacefully at home late on September 2. My condolences go out to Frank, Molly and Andy as we grieve her loss. She will always be remembered for her strength of character, excellent patient care and love for teaching osteopathic students and physicians. Her grandfather, C.D. (Pop) Heasley, has the honor of being the first osteopathic physician to be licensed in the state of Oklahoma. Yes, his license number is 1. •
The Student Osteopathic Medical Association (SOMA) at Oklahoma State University College of Osteopathic Medicine has a goal of not only being a political outlet for our students and conveying the student voice to the AOA, but we also strive to help improve quality of healthcare in our communities and country. As such, our first project of the 2017-2018 school year was focused on reaching a community in rural Oklahoma.

In August, SOMA partnered with the community of Perkins, Oklahoma to host the 2017 Annual Rural Health Fair. Rural Health Chairs, Catherine Peters, OMS-II and Gretchen Moore, OMS-II, worked with the city of Perkins to bring the Rural Health Fair to their community in conjunction with a community movie night and cookout. The event was staffed by several first- and second-year SOMA members, as well as members of the pre-SOMA chapter at OSU. Hundreds of community members attended and participated in activities including women’s health, OMM, nutrition, heart and lung sounds, anatomy presentations, and blood pressure checks. We also had face painting and a clown for the younger kids, provided by the Pediatrics Interest Group. We had the opportunity to speak with members of the community, young and old, and help promote a healthy lifestyle. It was a wonderful event and we are so grateful to the Perkins community for hosting us!

Moreover, with the mindset of improving healthcare within our community and our country, we are preparing for our annual fundraising event for our national philanthropy, the St. Baldrick’s Foundation. The goal of the foundation is to raise money for childhood cancer research. The loss of hair by chemotherapy and radiation can be a very difficult and traumatic experience for those undergoing cancer treatment, especially a child. So we encourage participants to raise pledge money to go bald, allowing participants and donors to symbolically recognize the struggle while also raising money.

The event will take place in the spring at The Hunt Club in downtown Tulsa. In addition to the head shaving, there will be live music and a silent auction.

SOMA also strives to contribute to the welfare of our osteopathic students. With this goal in mind, we have teamed up with the Student Government Association and the OSU administration to form a wellness committee to help improve overall student wellness on our campus.

Finally, our most important goal is to familiarize students with the purpose and advantages of osteopathic medicine as well as prepare members to meet obligations of the osteopathic profession. As we work through the upcoming ACGME merger, it is a growing concern that students will lose their osteopathic identity once they leave OSU-COM and become practicing physicians. We want our members to graduate from OSU with a strong sense of their osteopathic identity, understand what it means to be a D.O., how that makes them unique, and how they can maintain and incorporate these principles and practices into their careers. So, it is a goal of SOMA to be leaders on our campus in promoting the osteopathic principles and practice and share with students what makes them uniquely osteopathic. We agree with Sir Isaac Newton in the sentiment that we “only see farther by standing on the shoulders of giants”, and those giants are currently practicing osteopathic physicians. If you are a D.O. and would like to share with our students about why you chose osteopathic medicine, how that changes the way you practice, and what being a D.O. means to you, we would love to host you at one of our lunch meetings to share with our SOMA members. If you have any questions or would like to see how you could be more involved with SOMA and our events, please feel free to contact me at caitlin.way@okstate.edu.
Although our health care system has become more complex and many across our state don’t understand it, your patients can rest assured you are looking out for them. As regulations become more cumbersome, who is looking out for your best interests? Us! The OOA is fighting for you so you can DO and we need you to work alongside us. As a physician member, you can shape the future of the osteopathic profession.

RENUEW OR BEGIN YOUR MEMBERSHIP TODAY.

Together we can fight for the osteopathic profession and our patients.

NETWORKING
Get where you want to go faster by joining over 2,000 DOs in Oklahoma & have the opportunity to connect instantly.

MENTORSHIP
Shape the future of health care in Oklahoma by partnering with incoming OSU-COM students and guarantee they’re prepared to champion their patients and the profession.

ADVOCACY
Stand with us as we work on your behalf to:
» Ensure funding for OSU Medical Center & Physician Manpower Training Commission
» Protect Medicaid & provider rates
» Defend against scope of practice overreaches

QUALITY CME
Stay on the cutting edge of patient care with more than 60 hours of CME opportunities every year. Online, on-demand CMEs are now available at DOCME.org for education when and where you want it.

Visit the Membership tab at www.okosteo.org to join or renew your membership today!

Questions? Contact Maegan Dunn at 405-528-4848 or maegan@okosteo.org.
OSU Center for Health Sciences Unveils Oklahoma’s Largest State-of-the-Art Medical Simulation Teaching Center

The A.R. and Marylouise Tandy Medical Academic Building Features High-Tech, Computer-Programmed Simulation Manikins to Teach Medical Students

Kayse Shrum, D.O.
President, OSU Center for Health Sciences
Dean, OSU College of Osteopathic Medicine
President-Elect, Oklahoma Osteopathic Association

Oklahoma State University Center for Health Sciences launched a new era of advanced medical education in September, with the grand opening of the A.R. and Marylouise Tandy Medical Academic Building, a state-of-the-art teaching technology center featuring the state’s largest hospital simulation center. The simulation center brings to virtual life high-functioning simulation manikins that can mimic the human body in most every detail to give OSU medical students the closest thing technology can offer to real-life medical emergencies. The Tandy Medical Academic Building is located on the OSU Center for Health Sciences campus in Tulsa.

Our new life-like, computer-programmed simulation manikins can perform even beyond human actors as a medical teaching tool because these very realistic virtual patients can breathe, bleed, cry, sweat and be programmed to imitate most any medical emergency. The manikin simulators allow our medical students to safely experience situations they will encounter as physicians when patients hearts stop, breathing ceases, emergency births occur and surgeries are required. The Tandy simulation center will give students confidence in their skills and allow them to learn from mistakes without life-ending consequences. Our eventual goal is to be accredited as a national simulation center.
The simulation center has four units: an emergency room, operating room, intensive care unit and a maternity and child birth center. In addition to the manikins, computer programs allow students to conduct hands-on robotic and laparoscopic surgeries that visually mirror actual surgical situations. A Patient Centered Clinical Skills Lab, located on the second floor of the Tandy Medical Academic Building, is a scenario-based simulation using a combination of technology and standardized actors to allow medical students to learn patient skills in a controlled environment before working with actual patients.

In addition to the simulation center, the $40 million, four-story, 84,000 square-foot Tandy building includes a conference center, lecture halls, 18 patient examination rooms and an Osteopathic Manipulative Medicine lab. The academic teaching building was built with $8 million dollars in seed funding provided by the A.R. and Mary-Louise Tandy Foundation. The gift represents the largest private gift in the history OSU Center for Health Sciences. A number of other private donors contributed over $3 million towards the construction and equipment purchase for the Tandy Medical Academic Building. In total, over $11 million in private funds were secured from over 150 individual donors and foundations.

We are sharing this amazing center and its simulation-learning tools with our entire community of healthcare providers in addition to our medical students and residents. As part of our commitment to train primary care doctors and health care providers to serve rural and underserved communities of Oklahoma, we are inviting nurses, medical assistants, surgical techs, phlebotomists and other providers from around the state to join us for continuing medical education training, special education programming, conferences and even youth camps to extend the teaching capabilities of this academic building.
AOA CATEGORY 1-A CREDITS
WHENEVER • WHEREVER

The DO CME Education Center, a collaboration with other state associations, is a hub for on-demand programs, webinars, and live educational opportunities addressing a broad spectrum of topics covering practice management, healthcare regulation and relevant clinical issues.

Visit www.docme.org, create an account & access over 150+ CMEs instantly! With more constantly being added, DO CME is the place to get the latest on-demand lectures.

To watch OOA sponsored lectures on DO CME, type this link into your browser:
https://goo.gl/AjmBoZ

“Assisting Students in Achieving Their Dream of Becoming Osteopathic Physicians”

Do you know an OMS-II or OMS-III who deserves assistance along their osteopathic educational journey?

1. **Non-independent students** must have at least one parent, step parent or court-appointed guardian who is an Oklahoma resident and who has claimed the applicant as a dependent on his/her federal income tax return for the previous year.

2. **Independent students** must have lived in Oklahoma in some capacity other than as a full-time student at a post-secondary institution for a period of at least 12 consecutive months prior to matriculation to medical school.

**Eligibility Criteria**

1. Preference will be shown to applicants who have completed two years of osteopathic medical education and who indicate a desire to practice in Oklahoma.

2. While class standing and cumulative grade point averages are determining factors, your application, level of need and letters of support will be heavily considered during the decision-making process.

**Other Considerations**

**OEFOM Endowed Scholarship**

Applications due February 23, 2018
visit www.okosteoo.org for more details

$6,000 was awarded to last year’s recipients
Funds contributed to OEFOM are used for student scholarships and educational activities, and to main-
tain the OEFOM building. Please consider a tax-deductible contribution of $25, $50, $100, $250, $500
or a $1,000 or more to the Student Activity Fund, Student Scholarship Fund, or the OEFOM Building
Maintenance Fund.

Tax deductible gifts can be easily made to OEFOM:

- Make a secure donation online at www.okosteo.org (» Foundation Tab at top of page » Support the OEFOM –
  OEFOM Student Activity Assistance Program, OEFOM Endowed Building Maintenance Fund, or OEFOM
  Student Scholarship Program.

- Mail this form with your check or credit card information to 4848 N. Lincoln Blvd., OKC, OK 73105. Make
  checks payable to OEFOM.

- Fax your form to the OOA’s central office at (405) 528-6102.

Please indicate which program or fund your would like to support by checking
a box below:

☐ OEFOM Student Activity Assistance Program

☐ OEFOM Endowed Building Maintenance Fund

☐ OEFOM Student Scholarship Program

Credit Card Information:

Credit Card Type: American Express ___ Visa ___ MasterCard ___ Discover ___

Card No.________________________________ Card Exp. Date __________________

Card CID# (three digits on back of card) __________ Zip code: ______________

Name on Card _____________________________________________

Signature ________________________________________________ Gift amount: $ ___________
The American Osteopathic Association (AOA) convened for the 2017 House of Delegates at the Chicago Marriott Magnificent Mile Hotel July 21-23, 2017. The House of Delegates (HOD), which meets every July, brought together osteopathic physicians from every state to discuss and formalize a wide range of organizational policies and approve national leadership. The HOD also included several reference committee and bureau meetings which provided tremendous input on resolutions and governing policy for the profession.

The AOA House of Delegates included 509 delegates, including student delegates and representatives from each of the 35 osteopathic colleges. Divisional society representatives make up 474 of the entire delegation, which includes state societies as well as specialty societies. Every state receives one delegate automatically. Other state delegate positions are allocated based on the state’s AOA members as a proportion of national AOA membership, which are calculated every year. The District of Columbia and members of the military are also considered divisional societies along with the 50 states. This year, Oklahoma was allocated 16 delegates, including one student delegate. Oklahoma has 1,682 dues-paying members of the American Osteopathic Association which accounts for about 3.4% of the national delegation.

Only Michigan (52), Pennsylvania (45), Florida (42), California (34), Ohio (31), New York (25), New Jersey (23), and Texas (21) had more delegates, making Oklahoma the 9th largest contingent. All of these eight states have a population greater than that of Oklahoma, showing our dense osteopathic composition. Oklahoma also had eleven alternate delegates in attendance, including one student. Illinois also had 16 delegates, but has fewer AOA members than Oklahoma.

OOA Past President Duane G. Koehler, DO, was also in attendance. This year, Dr. Koehler represented the American College of Osteopathic Family Physicians (ACOFP) as its alternate delegate. In March, Dr. Koehler will assume the reigns as ACOFP President at the Annual Convention in Austin, Texas.

The OOA’s Executive Director and CEO, Lana Ivy, and I attended AOSED (Association of Osteopathic State Executive Directors) meetings earlier in the week. The AOSED meeting serves as the primary opportunity for state affiliate leadership to convene to discuss issues of importance for an ever-changing industry. One of the central items discussed was the creation and organization of a newly-formed report provided by Matt Harney, MBA
osteopathic consortium of state osteopathic associations. Membership to the consortium is not required but encouraged in an effort to share resources and co-market continuing medical education. AOSED’s annual business meeting is also held at this time.

Thursday, July 20
The AOA Board of Trustees held its meetings Tuesday, July 18 through Thursday, July 20. Also convening on Thursday was the A.T. Still Foundation Board. Kicking off AOA bureau meetings was the Credentials Committee with a luncheon meeting followed by the Bureau of State Government Affairs and Bureau of Socioeconomic Affairs. Oklahoma’s Chief Delegate David F. Hitzeman, DO, serves as Chair of the Bureau on Socioeconomic Affairs. That afternoon, the AOA hosted a town hall featuring Josh Kraushaar, political editor for the policy-focused National Journal. Mr. Kraushaar provided his insights regarding the direction of health care public policy. Also, AOA government affairs staff provided a public policy update followed by a question and answer period. After the town hall, AOA business concluded with the Committee on Rules & Order of Business meeting, which is also chaired by Dr. Hitzeman.

That evening, the OOA hosted a working dinner for the Oklahoma delegation to discuss various resolutions and to provide a general overview for the following three days. Dr. Hitzeman, as Chief Delegate, led the meeting. Many resolutions of interest were discussed, including topics related to continuing certification, continuing medical education requirements, AOA membership for medical doctors, and a resolution modifying student representation at HOD among many others.

Friday, July 21
Friday kicked off the first day of the full House of Delegates business, with Oklahoma delegates wearing matching OOA ties for the men and scarves for the women. It is customary to allow the OOA president to select the delegation accessory every year. A delegate orientation was offered for new delegates at 8 a.m. The full House of Delegates convened at 9 a.m., where several reports were provided to delegates, alternate delegates, and staff. One such report outlined the importance of the federal osteopathic political action committee, AOIA (American Osteopathic Information Association) PAC. The Oklahoma delegation was yet again proud to have 100% delegation participation (including alternate delegates) and submitted several thousand dollars in contributions to the AOIA PAC.

Every HOD resolution submitted is assigned and reviewed by a related reference committee. Committees include Educational Affairs, Professional Affairs, Public Affairs, Constitution & Bylaws, Resolutions, Ad Hoc, and the Joint/Board House Budget Review. Reference committees met Friday afternoon following the morning session.

That evening the entire Oklahoma delegation and guests, enjoyed a reception and dinner at Ruth’s Chris Steak House. The OOA was pleased to have the CEO of the AOA, Adrienne White-Feines and her husband Larry Feines, MD, attend a portion of the evening. Additional guests included the CEO of the Osteopathic Founder’s Foundation Sherri Wise, CPA. The delegation was also thankful to have Oklahoma’s student delegate, Ben Chadek-Feeley, OMS-II, and Oklahoma’s alternate student delegate, Derek Hill, OMS-II, along with several other students from OSU-COM. Following the reception, we transitioned to dinner where Oklahoma Osteopathic Association President Kenneth E. Calabrese, DO, provided welcoming remarks and then every attendee introduced themselves. The OOA would like to say a special word of thanks to Rich & Cartmill for sponsoring the evening’s dinner. Following dinner, delegates were encouraged to attend Oklahoma’s hospitality room at the hotel, which enhances delegation camaraderie but also serves as an excellent networking opportunity with delegates from other states.

Saturday, July 22
On Saturday, the House of Delegates convened at 7:30 a.m. for the nominations to the AOA Board of Trustees and other leadership positions for the following year. William S. Mayo, DO, of Mississippi was elected AOA President-Elect. Next up was the A.T. Still Memorial Lecture by Clinton Adams, DO. Dr. Adams spoke to opportunities that lie ahead for the osteopathic profession. “Rethinking our stance on pressing social, economic and philosophical issues, and the subsequent transformation to acceptance has led to the osteopathic profession’s growth and success,” Dr. Adams said. He also echoed Dr. Still’s famous quote, “I have no desire to be a cat, which walks so lightly that it never creates a disturbance. I want my footprints to be seen by all.” He also challenged all to “be change agents and embrace our role and responsibility, helping to change the house of medicine.” Dr. Adams serves as the CEO and President of Rocky Vista University.

Shortly before noon, the House began recognizing individuals

Clinton E. Adams, DO, FACHE
and organizations for its House of Delegates Annual Awards. The AOA recognized honorees for the “STAR” Strategic Team Award and Recognition,” “George Northrup Medical Writing Award”, and several other presidential citations.

The OOA is extremely proud that OSU-COM’s Project ECHO was recognized for its effort to help solve Oklahoma’s primary care physician shortage. Project ECHO extends special care capacity in rural Oklahoma to diagnose and treat patients with complex health conditions. OSU-COM launched its first ECHO clinic, a psychiatry TeleECHO clinic, last November. Since then, programs specializing in obesity medicine, HIV/AIDS/Hepatitis C, and mental health and addiction medicine have been added.

STAR is presented for contributions made by state and specialty affiliates, osteopathic medical schools and nonpractice affiliates that enhance the culture of osteopathic medicine. OSU-COM’s Project ECHO Medical Director, Joseph R. Johnson, DO, represented the university for the award.

Following the awards luncheon, the House completed discussion on a host of resolutions. The House considered modifications to the Osteopathic Oath, changes to certification requirements, and increased transparency to the AOA leadership election process.

One resolution that passed the House requires the AOA to prepare a report evaluating the changes to the five components of the osteopathic continuing certification (OCC) approved by the Board of Trustees at the 2017 midyear meeting. Additionally, a resolution extending membership to medical doctors was approved and now advances to the Committee on AOA Governance & Organizational Structure.

At 4 p.m., incoming AOA President Mark A. Baker, DO, was sworn in by outgoing President Boyd R. Buser, DO, and gave his inaugural address. Dr. Baker specializes in diagnostic radiology from UNTHSC/TCOM and completed his residency in diagnostic radiology at Fort Worth Osteopathic Medical Center.

The following is Dr. Baker’s inaugural remarks in part:

Today I want to talk about us. That’s right – us.

• Everyone in this room.
• Our profession.
• And our association.

My focus this year revolves around three areas:
• Improving the communication and relationship with our affiliates,
• Engaging the youth of our profession, and
• Promoting unity within our osteopathic family.

I’d like to have a candid conversation about where the osteopathic profession is currently, and our many opportunities for the future. We need to remember – that we are all part of the same family – the osteopathic family!

Think about it! Each and every one of you in this House is here for a few common reasons:
• You all have a love of our osteopathic profession,
• You all want to give back, and
• You all want to ensure that the future of osteopathic medicine is bright.

As part of the same professional family, we have a shared culture – that of osteopathic medicine – our distinctive philosophy and practice of medicine.

Throughout its history, our profession has addressed many challenges – and not only survived, but prospered. And why should now be any different? Are we not just as committed as our forefathers? We need to embrace the opportunities and changes before us and ensure our future prosperity.

Over the past year, many of you have heard me talk about the growth of our profession. With the addition of the graduating class of 2017, we have officially surpassed 130-thousand active DOs and OM students. Our family is getting larger, and that means . . . more chairs at the table.

Our profession is in a position that most organizations would give their right arm to have:
• We are rapidly growing – one of the fastest growing segments of healthcare professionals.
• We are becoming significantly younger – 53-percent of all DOs are under 45.
• And we are becoming more diverse – 46-percent of DOs under 45 are female, and since 2011 we’ve had a 63-percent increase in women DOs under the age of 35.

Our challenge . . . is to take advantage of this rapid growth, to harness this energy for a common cause – moving our profession forward and remodeling the AOA for future generations of DOs.

This future . . . includes the opportunity for MDs to join us at the table – to become AOA certified, to become members, and to practice osteopathically. But let’s be perfectly clear . . . they are joining us . . . we are not changing to become them. Our mission continues to be – to advance the distinctive philosophy and practice of osteopathic medicine.

Over the past several years, the AOA has undergone some very significant changes – changes that were necessary. Even our founder, A.T. Still, understood the need for change, when he said, “Let us not be governed today by what we did yesterday, nor tomorrow by what we did today, for day by day we must show progress.”

But change can be uncomfortable, and sometimes change is disruptive. Here at the AOA, change has put pressure on several segments of our family.

This brings us to my first area of focus this year – Improving the communication and relationship with our affiliates.

As the AOA grows and changes to meet the challenges of today and tomorrow, it’s important for us to circle back and be sure all of the family – including our affiliates – are healthy . . . and that everyone has a shared strategic vision of our future.

Today . . . we have an opportunity to strengthen our alignment with our affiliates, both state and specialty societies. We must work with our them to increase their level of relevance to the new generation of DOs. Maximizing the strength of both our affiliates and the AOA advances our osteopathic profession.

This process must be based on clear, direct, and honest communication around issues that are mutually beneficial to all. We have an Affiliate Alignment Task Force composed predominantly of executive directors of our state and specialty societies, addressing areas of common concern. I look forward to the recommendations of this task force. My commitment to both AOSED and SOSE is that we – you and I – will sit down and have a face-to-face meeting, discussing these recommendations. I assure you – our affiliates are an important and integral part of all that we do as the AOA and the osteopathic profession.

This brings us to my second area of focus this year – engaging the youth of our profession.

Today, the AOA has a multitude of opportunities in front of it; many of them arising out of a new generation of DOs and their changing needs and wants. They have dedicated themselves to the osteopathic profession. Now we must acknowledge them, respond to their needs and build an even stronger sense of belonging to the family!

As our residency and fellowship programs transition to the Single Accreditation System, it is important for them to apply for and obtain osteopathic recognition. Remember – Osteopathic GME is not going away – it will merely be known as a program with osteopathic recognition.

Repeatedly, the overwhelming majority of our osteopathic medical students have told us -- they want to train in osteopathically-recognized programs. We must give them that opportunity and increase our capacity.

We must talk to educators and students about the value of osteopathic board certification, its assessment of our osteopathic competencies in a physician-friendly format that is convenient and cost-effective.

We have an opportunity to engage the youngest members of our profession – ensuring that the resources we provide them are cutting edge, but at the same time grounded in osteopathic philosophy . . . and encouraging them to be active, contributing members of the family.

We must welcome their voices to join in the discussion. Our younger members bring with them a heightened level of energy and inquisitiveness into our profession. It is that type of energy and passion and willingness to think in new and innovative ways that we, as an association, need.

This energy and passion for our profession are vital for our Boards, our governing bodies and our affiliates. Give them a seat at the table and encourage them to get involved. Help them develop their leadership skills, because they are our future!
Finally, this brings us to my third area of focus this year – promoting unity within our osteopathic family.

Very simply...our future is dependent upon our unity.

We must all work together to increase the level of **trust** and **respect** that we have for each other’s contributions to the profession. It’s okay to disagree, but let’s be constructive and work together. Because at the end of the day...we are a family.

Many of you may know that for five years I had the pleasure of serving as Speaker of this House. I have great faith in this House of Delegates and its policy-making authority for the AOA.

It is important for us **all** to remember – that we are a physician-directed and driven association. That the policies adopted by this Body direct the actions of the Board of Trustees and the administration. These polices are established by this HOD, with representation of DOs from across this great country. Delegates, thank you for your commitment and all that you do for the AOA.

So, how do we move our profession forward. Former University of Texas football coach Darrell Royal used to say it this way, “You dance with who brung ya!” Translating that out of Texan for you, it means that you rely on those who got you where you are - yes, ...“us” - you and me. Everyone in this room...from our students to our most seasoned leaders – the family.

This profession has given everyone in this room a great opportunity. You were given the opportunity to become an osteopathic physician. You were given the opportunity to serve mankind by improving health. And you were given the opportunity to provide a fulfilling and comfortable lifestyle for yourself and your family.

But with this opportunity...you also have an obligation. You have an obligation to give back to:

- Our current students,
- The osteopathic profession, and
- The AOA.

We all owe this profession more than we can ever repay.

Former AOA President Norm Vinn said it this way in his inaugural speech – we must “harness the strength of our culture to enhance our strategic plan and preserve our unity.”

**My** call to action today, for this distinguished body, is that each and every one of you join me in improving the communication and relationship with our affiliates...engaging the youth of our profession...and promoting unity within our osteopathic family.

Last year, President Buser challenged us to “let you inner DO out!” Allow those characteristics that define DOs to shine brightly in everything that we do, propelling our profession forward.

In other words, our future is in our own hands, and it shines brightly. In fact, over the last year, at every COM I visited, I’ve told the students that their future is so bright that “you gotta wear shades.”

**Sunday, July 23**

The House of Delegates convened Sunday morning at 8 a.m. to approve nominations to the AOA board of trustees and board leadership positions. Final action had been taken on all resolutions by the conclusion of business on Saturday. Oklahoma’s only member of the AOA Board of Trustees, C. Michael Ogle, DO, was elected to the position of second vice president. Dr. Ogle served as OOA President in 2015-2016.

The OOA is incredibly proud of all the physicians who served our state at the AOA House of Delegates and appreciates the contributions made to ensure osteopathic excellence. Oklahoma’s 2017 delegation was as follows:

**Delegates**

1. Kenneth E. Calabrese, DO
2. C. Michael Ogle, DO
3. Gabriel M. Pitman, DO
4. David F. Hitzeman, DO
5. Layne E. Subera, DO
6. Joseph R. Schlecht, DO
7. Dennis J. Carter, DO*
8. LeRoy E. Young, DO
9. Kayse M. Shrum, DO
10. Melissa A. Gastorf, DO
11. Timothy J. Moser, DO
12. Christopher A. Shearer, DO
13. Ray E. Stowers, DO
14. Clayton H. Royder, DO
15. Jonathan K. Bushman, DO
16. Ben Chadek-Feeley, OMS-II

**Alternate Delegates**

1. Thomas J. Carlile, DO
2. Richard W. Schafer, DO*
3. Dale Derby, DO
4. Jason L. Hill, DO
5. William J. Pettit, DO
6. Tammie L. Koehler, DO
7. Arlen K. Foulks, DO*
8. Jeffrey L. Shipman, DO*
9. Jeffrey A. Gastorf, DO
10. Stanley E. Grogg, DO
11. Kristopher K. Hart, DO*
12. Michael K. Cooper, DO
13. Trudy J. Milner, DO
14. Ronnie B. Martin, DO
15. Vacant
16. Derek Hill, OMS-II

*unable to attend

Dr. Hitzeman serves as Chief Delegate.

More information on the AOA Annual Meeting and House of Delegates can be found online: [https://www.osteopathic.org/inside-aoa/events/annual-business-meeting/Pages/default.aspx](https://www.osteopathic.org/inside-aoa/events/annual-business-meeting/Pages/default.aspx)
Welcome new members!

The OOA Board of Trustees welcomes the following new members to the OOA family!

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Practice</th>
<th>City</th>
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<tbody>
<tr>
<td>Elise Kuykendall, DO</td>
<td>Family Medicine/OMT</td>
<td>Yukon, OK</td>
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<td>Theodore A. Mickle, DO</td>
<td>Family Practice</td>
<td>Oklahoma City, OK</td>
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<td>Kara M. Beair Butler, DO</td>
<td>Internal Medicine-Pediatrics</td>
<td>Tulsa, OK</td>
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<td>Arvin J. Pourtorkan, DO</td>
<td>Family Practice</td>
<td>Edmond, OK</td>
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<td>Ashley N. Shelley, DO</td>
<td>OB/GYN</td>
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<td>Kody K. King, DO</td>
<td>Orthopedic Surgery</td>
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<td>Terri O. Reed, DO</td>
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<td>Michael C. Rommen, DO</td>
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<td>Valerie E. Robinson, DO</td>
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<td>Casey L. Cochran, DO</td>
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<td>Daniel B. Wimmer, DO</td>
<td>Pathology</td>
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INTRODUCTION

Recent studies have revealed that 100 percent of human beings do, in fact, eat (no reference needed). Not everyone has CHF, or COPD, but you would be hard-pressed to find anyone alive who does not eat. Now that this groundbreaking data has been revealed, think back to your last patient and see if you can remember any information at all about their nutritional status. The ironic thing is that most of us cannot! We can recall any information required about their kidney disease, but nutrition is not something that we stress to be of importance. If 100 percent of patients eat, then nutritional support should be as reflexive as DVT prophylaxis, and lack of nutrition is by no means benign.

Malnutrition can delay wound healing, prolong hospital stays, worsen chronic illnesses, and create electrolyte abnormalities precipitating additional acute problems. One cross-sectional study by Mowe and Bohmer in 1991 showed physicians only caught 36 percent of malnourished patients.¹ That means that 64 percent of malnourished patients were leaving the hospital without proper nutrition follow-up, and that was over 15 years ago! In 2017, our patients are living longer with their chronic conditions, and the population of elderly patients is expanding. There is also the problem of nutrition medicine not being a focus in medical school, as it is not on any of our board exams.

The result is that we, as the new generation of doctors, do not value the impact of nutrition and are not properly educated in diagnosing and treating malnutrition in our patients. Even
we, as osteopathic physicians, who value our holistic view of the patient, have allowed nutrition to fall by the wayside. Recent surveys have shown that as many as 33 percent of patients admitted to the hospital have some degree of malnutrition, and so it is time we as physicians paid closer attention to this growing issue.²

That is the purpose of this article — to offer explanation and guidance to osteopathic physicians in an effort to improve our patients’ quality of life.

HOW CAN WE BE BETTER AT THIS?

The American Society for Parenteral and Enteral Nutrition (or ASPEN) defined malnutrition as “an acute, sub-acute or chronic state of nutrition, in which a combination of varying degrees of over-nutrition or under-nutrition with or without inflammatory activity have led to a change in body composition and diminished function.”³ Diminished function is the key here, and it is why physician recognition of this process must improve. For the sake of simplicity, this article will focus only on the under-nutrition portion, as over-nutrition is something that we, as Americans, see quite routinely.

ASPEN also highlights three main types of patient “scenarios” where clinicians should be extra vigilant of malnutrition. The first and most obvious scenario is in the context of starvation or environmentally-related deprivation. It makes sense that people who do not eat for prolonged periods of time are at risk and nutrition should be consulted as support. With correct intervention, most of these patients can be successfully rehabilitated. The next two are easy to remember because they appear in the context of acute and chronic illness.

By acute illness, I mean things like trauma, closed head injuries, severe burns and other major processes such as sepsis and respiratory failure. It is no wonder that energy expenditure, as well as protein requirements, are elevated in these patients, which in turn puts them at risk for malnutrition. They may have even been completely normal before the acute illness occurred. What makes things worse is that nutritional support is often delayed, as the primary focus, naturally, is on stabilization.

Chronic illness is, of course, what medicine thrives on, and that features but is not limited to CHF, diabetes, cancer (in general), inflammatory bowel diseases and kidney diseases. In chronic processes, response increase to demand is milder, but results in a chronic loss of lean muscle mass and fat. The losses are slow and far less dramatic than the first two scenarios mentioned. The result is that it may go completely unnoticed by the patients and, worse, their physician. Treatment for these patients requires diets that are tailored to the disease process and focused on the preservation of muscle mass.²⁴

**BEFTER IDENTIFYING MALNUTRITION: THE NEXT STEP**

The second step, now that we know in which scenarios to be worried, is how to properly spot these patients. Most of these methods of improvement are actually all based around more thorough history taking, and are completely free and require minimal time.

Assess recent intake vs. current energy needs. All this would take is a few extra questions to the patient or their provider, such as: “Have you been eating less then you normally do recently?” Understand that an actual measurement of the patient’s current energy needs would be best left up to nutrition. However, these questions can help point you in the direction of a consult.⁵

Assess weight change from baseline. Again, this can be a simple question of “Have you lost any weight recently?” It may be difficult though because as said before, in chronic illnesses the patient may not notice. A quick look at the patient’s last visit can be helpful to find a baseline weight. Be aware in those with significant edema, as this can mask the weight loss. If you are suspicious of weight loss, especially in chronically-ill patients, a nutrition consult could never harm them.⁵

Physical exam. This is an area that we can excel in as physicians, if history fails us. It does not even require any alteration of the way you conduct your physical, all that is needed is to make a few additional visual observations. The main thing to take note of is any loss of body fat or muscle mass.

For body fat, look for sinking or a hollow look around the eyes, loss of mass in the upper arms (triceps), lower back, or any sunken ribs. Depleted body fat also can look like loose skin, depression between the ribs, and hollowing of the skin.⁶

For muscle mass, look at the upper body, more specifically the clavicles, back of the hand, scalpula, and especially wasting or depression of the temples. Any prominent or protruding bones, such as protruding hip bones, should throw up a red flag. It is important again to note the presence of edema, as this can mask the physical signs that were mentioned above.⁶

Grip strength. Surprisingly, grip strength has come to be of importance in this whole assessment. Malnutrition causes

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² ASPEN also highlights three main types of patient “scenarios” where clinicians should be extra vigilant of malnutrition.
³ Diminished function is the key here, and it is why physician recognition of this process must improve.
⁴ For the sake of simplicity, this article will focus only on the under-nutrition portion, as over-nutrition is something that we, as Americans, see quite routinely.
⁵ Assess recent intake vs. current energy needs.
⁶ Assess weight change from baseline. Physical exam.
both loss of muscle mass and inhibits muscle protein synthesis, which in turn affects the patient’s strength. Handgrip strength, therefore, is now being used as a marker for nutritional status. It has been shown in clinical trials to be a predictor of mortality and overall nutritional status. It is non-invasive and requires no blood that may further deplete the patient. The proper way to measure strength is with a dynamometer, but it is not really needed, as the effect can be noticed with the patient simply squeezing your hands, just as in normal strength testing. In addition to testing for symmetry, also test for strength, and consider it a red flag when you encounter a very weak patient.

ALBUMIN AND PRE-ALBUMIN: IT’S A TRAP!
It is important to point out first that pre-albumin is NOT a precursor to albumin. Both proteins are made by the liver, but serve very different physiologic purposes. Pre-albumin, also known as transthyrethin, is actually a thyroid hormone transport protein. It has a shorter half-life than albumin (almost two to three days shorter) and is most importantly, expensive to order. Albumin, as we know, binds any different cations and vitamins in addition to regulating the oncotic pressure of the blood.

Now, these two molecules have been touted in the past to be markers of malnutrition, but as the title of this paragraph says, “It’s a trap!” If you search the ASPEN guidelines you will find no mention of these molecules, and for good reason. Although there is some conflicting evidence, most of the literature points to pre-albumin and albumin as “negative” acute phase reactants. This means that they fall with the patient’s severity of disease, and can be totally separate from their nutritional status. A correlation can be made to other acute phase reactants, such as transferrin. Albumin levels also fluctuate with fluid status, and as a matter of fact, pre-albumin and albumin levels can be completely normal in the setting of malnutrition.

We are taught to take all lab results within the context of the bigger picture, and a misunderstanding of what these two molecules are, and more importantly are not, can lead to harm for our patients. It can lead us away from a diagnosis of malnutrition, away from consulting the experts, and can extend our patient’s road to recovery. The truth of the matter is that we as physicians have little to no training in nutrition medicine. So, if these two lab tests are no longer useful, then what can we do to identify these patients?

A SPECIAL KIND OF MALNOURISHED PATIENT
Once these patients are identified, the goal is then to pump them full of as much food as possible. Right? So, you can guess at the answer to that question, and the reason many of us may know already. It is the elusive process simply known as the refeeding syndrome. The syndrome remains elusive for two main reasons: 1) it is complicated, and 2) not a lot of research has been done in the field. More on this later — history lesson first.

REFEEDING SYNDROME: A BRIEF HISTORY
The first notions of the potential complications of feeding a severely malnourished patient came out of articles published right after the end of the Second World War. The term was originally coined by Keys et al. in 1944 after studying a series of eight men who purposely starved themselves for 6 months in conscientious objection to the war. After feeding these men, some of them developed heart failure, which was thought to be due to severe hypophosphatemia; now a hallmark of refeeding syndrome.

A year later in 1945, patients liberated from concentration camps flooded into Europe’s health care infrastructure. The average caloric intake of prisoners was 1,000 calories a day, with the weaker receiving only 500 calories a day due to the inability to forage. As these patients were fed, there were high incidences of sudden unexplained death after admission and unexplained death after the patient appeared to be improving. Four years later, a similar event happened in Japan with similar physical and mortality findings. Even on the other side of the world, scientists were finding the same things.

PATHOGENESIS
Understanding refeeding syndrome requires a better understanding of fed and fasting physiologic states. Generally, a state of starvation, or fasting, is described as a catabolic state where the body has switched from carbohydrate metabolism to fat and protein metabolism as its primary source of fuel. This switch of fuel sources is the catalyst for the myriad of other alterations the body performs, and it begins with the GI tract sensing a drop in caloric intake. After eating, the body upregulates insulin and downregulates glucagon, and in a fasted state the reverse happens, with less circulating levels insulin and more glucagon.

The pancreas responds to the drop in glucose seen by the intestines by modulating its secretion of insulin. Insulin may be the most crucial factor in the whole adaptation process, and has been identified as the main catalyst behind the development of refeeding syndrome. Insulin’s effect drives the storage of glucose as adipose and the synthesis of other fatty acids. Elevated levels of glucagon initiate breakdown of these adipose stores to use as energy. Metabolism of adipose
stores releases free fatty acids into the blood. Along with ketone bodies, these two molecules serve as the body’s new sources of material for its many biological processes, with fatty acids serving as the main source.\textsuperscript{13,14} Survival time after the metabolic switch, therefore, is mainly dependent on the size of usable adipose tissue. This has interesting implications on patients that may seem otherwise to be in perfect health, such as body builders. Because of their lower amounts of adipose, their lean body mass may waste very quickly during times of prolonged starvation. So, while these patients seem at the peak of health, they may require more attention than you may think. The other main source of fuel is derived from glycogen stored in the muscles and liver. The liver and muscles store about 300 grams of glucose as glycogen which can provide up to 24 hours of energy. The breakdown of glycogen produces ketone bodies, and through gluconeogenesis the body converts these ketones into glucose.\textsuperscript{13,14}

In a fasted state, muscle burns primarily fatty acids as fuel. As the fasted state deepens and glycogen is depleted, loss of lean body mass occurs as muscle begins to be broken down into their component amino acids. The proteins are then further broken down into ketones. To preserve muscle mass for as long as possible, basal metabolic rate can decrease by almost 25 percent. Cell volumes of the various organs also drop for the postulated reason of the loss of intracellular storage macromolecules. Finally, the brain switches its main energy source to ketones and glucose alone. It does not use fatty acids, not because it does not have the capability, but because the fatty acid is too large to pass through the blood brain barrier.\textsuperscript{13,14}

The problem with refeeding syndrome is when a normal physiologic response occurs in a physiologic state that is no longer compatible with that response. The body is very adaptable, even to the point of creating its own energy, if none is available from food. However, this adaptation has its limits, mainly in the cofactors that are required for metabolic processes that the body cannot make on its own. Insulin secretion signals to the body to resume usual methods of energy production and storage, however, many of the factors required from those pathways have been dangerously depleted. Restarting normal mechanisms depletes them even further, resulting in multisystem chemical and electrical abnormalities.\textsuperscript{13-15}

It is important to note that in some cases serum electrolyte levels may be normal due to renal adaptation and retention, as well as other mechanisms such as recruitment from bone, especially if an acidosis is present. Severely malnourished patients may also have normal albumin due to decreased breakdown of proteins, and due to fluid shifts into the interstitium that may make serum albumin levels appear falsely high.\textsuperscript{14}

It also does not always take month of starvation to become malnourished. Any patient with negligible food intake for more than five days has an increased risk of refeeding syndrome.\textsuperscript{1} The syndrome generally occurs within three days and usually no longer than ten days after refeeding.\textsuperscript{14}

PREVENTION BEFORE ALL ELSE

So, it was mentioned before that there has not been a whole lot of research done on refeeding syndrome. As a matter of fact, there is no current, consistent definition with which to make the diagnosis. Treatment is symptomatic, and the primary emphasis in the literature has been placed on prevention.\textsuperscript{16} It seems to me it would be rather challenging to create randomized trials without a consensus definition.

Thankfully, we do have an actual criterion for a patient that is at high-risk for this syndrome, as published by the National Institute for Health and Clinical Excellence (NICE) in 2006.\textsuperscript{17}

\begin{itemize}
  \item Major Criteria (one required)\textsuperscript{17}
    \begin{itemize}
      \item BMI less than 15 kg/m\textsuperscript{2}
      \item Unintentional weight loss greater that 15 percent within the last 3-6 months
      \item Little or no nutritional intake for more than 10 days
      \item Potassium less than 3.5, phosphate less than 2.7, or magnesium less than 1.6
    \end{itemize}
  \item Minor Criteria (two required)\textsuperscript{17}
    \begin{itemize}
      \item BMI less than 18.5 kg/m\textsuperscript{2}
      \item Unintentional weight loss greater than 10 percent within the last 3-6 months
      \item Little or no nutritional intake for more than 5 days
      \item A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics
    \end{itemize}
\end{itemize}

These criteria have allowed for some quantification of this special population. In one of the only epidemiologic studies to quantify the high-risk population, it was found that about 9 percent of 1,661 patients examined were flagged by dietitians as being high-risk for refeeding syndrome. They also found that these patients on average weighed 13 kilograms (28.7 lbs) less, had a four day longer hospital stay, and required three times more time dedication by the dietitian. Speaking in terms of electrolytes, 52 percent of high-risk patients experienced significantly low levels of potassium, magnesium, or phosphate within seven days of assessment, with 9 percent having “very low” levels.\textsuperscript{18} This review, con-
ducted in Australia, demonstrates not only the time require-
ment these patients demand, but also their longer hospital
courses and the very real risks that occur during the initial
stage of refeeding.

A separate audit of 102 patients showed that 22 of those (21.5
percent) were at high-risk, and only 32 percent of those were
treated per best practice with 9 percent progressing to clinically
diagnosed refeeding syndrome with the classic elec-
trolyte aberrancies and complications. This addresses one
of the serious concerns that has been raised in the handling
of this syndrome. Lack of physician education has resulted
in widespread under-reporting and under-treating of high-
risk patients, and has consequences that have not yet been
quantified. Even from dietitian to dietitian within the same
hospital there are variations of approach, with some using a
more cautious approach and some who elect to be more ag-
gressive in terms of both feeding and electrolyte repletion.

In general, the overall body of literature for this disease
process is poor. There remains no consensus definition for
diagnosis, the criteria used to access risk lack rigorous sen-
sitivity and specificity, the epidemiology of this population
is only briefly described in one paper, and many of the rec-
ommendations put forth in other safety protocols are based
on prior experience. The literature is in consensus on
one thing, and that is that treatment efforts should be aimed
towards prevention. The most effective means of bringing
this about is through consistent and evidence-based practice
guidelines and screening protocols.

For this reason, we at ASPEN have now begun work on a
consensus clinical guideline for the prevention and treat-
ment of refeeding syndrome. There are other protocols in
other parts of the world to this effect, with the most recent
published four years ago, by the Irish Society for Clinical
Nutrition and Metabolism, or IRSPEN. The proposed proto-
col would be entirely based in current literature recommend-
dations with compensations for renal failure, an aspect left
out by previous protocols.

**ASPEN CONSENSUS ON REFEEING SYNDROME:
COMING SOON**

The protocol would consist of three sections: 1) screening,
2) recommendations for feeding rates, and 3) repletion of
 Electrolytes. The screening of these patients would be using
the NICE high-risk guidelines published in 2006. Although
somewhat lacking in sensitivity and specificity, they have
been shown to be useful for screening. Screening by
the dietitians has already begun at our facilities, and has been
an effective way to identify these patients without significant
detection variability between providers.

Feeding rates would be based on data collected from previ-
ous studies and currently published protocols in other parts
of the world. Because of the relative lack of controlled data
on the topic of feeding rates, the main goal here is to consist-
tently treat our patients with rates that have been previously
shown to be safe by other groups. These recommen-
dations for feeding rates would vary for patients show-
ing either moderate or severe malnutrition, and in the three
main feeding methods: 1) patient driven enteral feeding, 2)
enteral feeding tubes (i.e. NG, OG, PEG, PEJ tubes), and 3)
parenteral feeding.

The final phase is the safe and effective repletion of potas-
sium, magnesium and phosphate. Other protocols, such as
the IRSPEN Refeeding Protocol propose suggestions for
repletion without accounting for decreased renal function.
Our protocol would be adapted in this manner, and would
allow for us to give evidence-based recommendations on the
repletion of patients with chronic kidney disease stages I-
IIIa (leaving stage IIIb and IV to clinician discretion). This
phase would also include recommendations for daily thia-
mine and multivitamin supplementation.

The creation of an effective infrastructure using a consistent
protocol will not only allow us to screen and treat with ef-
ficiency, but will be vital in the continued study of this dis-
ease. It will allow us to more easily study these population
groups and conduct randomized, control trials to further ad-
vance our management. It will also allow us to easily adjust
our practice based on new data, and will unite our efforts in
caring for these patients through consistency and evidence
based practice.

**IN SUMMARY**

We as physicians may have missed the mark, but there is
hope for us yet. Thankfully, we have the consult of expert
dietitians, and so our job is made a great deal easier. The
primary areas in which we can help our patients is to know
when to look for malnutrition, knowing what to look for, and
knowing who to talk to about our findings. By early inter-
vention we can decrease hospital stay, improve wound heal-
ing, and accelerate recovery from acute and chronic illnesses
alike. If there was a pill that did all that, it would be as com-
mon as metformin. The ASPEN website is also an amazing
resource for continued learning and further support.

**TAKE AWAY**

- The three scenarios to look for malnutrition: deprivation,
  acute illness and chronic illness
• Add questions to your history assessing recent intake and weight changes from baseline
• To assess body fat look around the eyes, arms and ribs
• To assess muscle mass look at the clavicles, dorsum of the hand and the scapula
• Grip strength has been shown to be an accurate marker of nutritional status
• Albumin and pre-albumin have been shown to be inadequate markers
• A certain percentage of malnourished patients are at high risk for refeeding syndrome
• Refeeding syndrome is a constellation of abnormalities caused by normal physiologic responses occurring in non-physiologic conditions
• The mainstay of treatment for refeeding syndrome is prevention
• ASPEN is creating a consensus guideline to help guide our practice

REFERENCES
STATE SUPREME COURT STRIKES DOWN CIGARETTE TAX, OOA SEEKS SPECIAL SESSION

On August 10, the Oklahoma Supreme Court ruled Senate Bill 845, a bill expected to generate $215 million in new revenue from increasing the price of cigarettes by $1.50/pack, to be unconstitutional. SB 845 dubbed the price increase a “cessation fee” rather than a tax in an attempt to avoid the three-quarters support required for tax increases. The Oklahoma Health Care Authority, which manages the state’s Medicaid program, was set to receive $70 million of the new funds beginning August 24. SB 845 was set to also allocate funds to DHS and the Department of Mental Health. The loss of matching federal funds increases the fiscal impact to nearly $500 million.

Following the ruling, Governor Fallin stated, “These agencies and the people they serve cannot sustain the kind of cuts that will occur if we do not find a solution. My belief is we will have to come into special session to address this issue.” However, Republican legislative leadership appears to be less certain. In a press release following the ruling, Oklahoma Speaker of the House
Charles McCall said, “We have some ideas on how to address the budget, but there is some uncertainty right now regarding additional court challenges. We are very early in the fiscal year, so we do have some time to develop a sound plan that will give our agencies some certainty as they fulfill their duties and manage programs over the next 10 months. I have also communicated with Minority Leader Scott Inman and asked him to provide in writing any ideas the minority caucus is willing to support.” Rep. Kevin Wallace, the chair of the House Appropriations & Budget Committee, said directors from the impacted agencies have informed him they can currently operate for the foreseeable future without changes to services while the Legislature works on a plan.

Meanwhile, House Democrats have met with Gov. Fallin this week to discuss prospects for a special session and new revenue streams. House Democratic Leader Scott Inman said, “The governor is trying to put new revenues on the table. What those look like and what rate is still up for discussion.” Reportedly, these items include an income tax increase on top earners, an increase in the gross production tax on natural gas and oil, and taxing certain services. Lawmakers have scheduled additional meetings in the coming days and weeks to monitor court challenges and to plan a path forward.

The OOA has been forthright in urging an immediate and permanent solution. “We urge Governor Fallin to immediately call a special session and implore the legislature to find a sensible, long-term solution to our state’s budgetary woes,” said Oklahoma Osteopathic Association President Kenneth E. Calabrese, DO. “Access to quality health care must always be our top priority. Every day that goes by without a fiscal solution is a day our patients suffer. Our state leadership must consider all revenue-raising measures to ensure the wellbeing of Oklahomans.”

On August 31, the Oklahoma Supreme Court narrowly ruled to uphold another major budgetary item for the current fiscal year—the motor vehicle tax. This past legislative session, lawmakers removed the sales tax exemption on vehicles which adds a 1.25% tax to the 3.25% excise tax and is expected to generate $123 million in revenue.

As of the publishing of this article, Gov. Fallin announced her intention to initiate a special legislative session. “I am planning on calling a special session beginning September 25 for legislators to adjust the current fiscal year budget,” said Fallin. “A formal call for a special session will be issued in the next few days, but I wanted to announce my intention to call a special session for planning purposes. I also want Oklahomans to know we are working diligently to address the fiscal matters of our state.”

2017 HEALTH CARE BILLS

Dozens of important health care bills were approved by our state legislature in 2017. A summary of senate bills impacting health care is below:

- Senate Bill 30: Adds the following language to certain facilities or clinics where abortions are performed: “There are public and private agencies willing and able to help you carry your child to term, have a healthy pregnancy and a healthy baby and assist you and your child after your child is born, whether you choose to keep your child or place him or her for adoption. The State of Oklahoma strongly encourages you to contact them if you are pregnant.” The bill removes a provision contained within the Humanity of the Unborn Child Act that required the posting of certain signage within public restrooms and directs the State Department of Health to use its official, online social media platforms to promote the website created within the Act.

- Senate Bill 77: Adds OSBI (Oklahoma State Bureau of Investigation) forensic laboratory personnel to the list of first responders authorized to administer an opiate antagonist without a prescription to individuals exhibiting signs of an opioid overdose.

- Senate Bill 207: Requires the medical examiner’s office to redact the cause of death information before
autopsy reports are publicized.
• Senate Bill 229: Removes age limitation for certain types of mental health treatment.
• Senate Bill 478: Creates the Health Care Choice Act. The bill requires financial solvency for out-of-state health insurance companies who offer coverage in Oklahoma.
• Senate Bill 645: Adjusts the Oklahoma Medicaid False Claims Act. The bill modifies civil penalties owed to the State of Oklahoma from a current fine schedule to civil penalties consistent with the Federal False Claims Act.
• Senate Bill 652: Authorizes the Secretary of Health and Human Services to apply for grant funding from the U.S. Department of Health and Human Services for the purposes of identifying health disparities and assessing utilization strategies to prevent complications relating to sickle cell disease.
• Senate Bill 682: Updates eligibility requirements for a license to practice podiatric medicine. Beginning March 1, 2018, an applicant for temporary licensure must complete a three year podiatric surgical residency.
• Senate Bill 726: Modifies definition of telemedicine, specifies requirements to validate the physician-patient relationship.
• Senate Bill 730: Eliminated the outdoor smoking ban at veteran’s center set to begin January 1, 2018.
• Senate Bill 734: Allows the Mental Health Board to promulgate rules for certain employees employed by a tribe or tribal facility that provides behavioral health services, or by an Oklahoma or U.S. Veterans Affairs facility.
• Senate Bill 741: Allows the Oklahoma Health Care Authority and the Health Department to collaborate with city/county and county health departments along with other relevant stakeholders to develop a pilot program that seeks to encourage the appropriate use of primary care services rather than emergency room utilization.
• Senate Bill 765: Prohibits minors from using tanning facilities.
• Senate Bill 770: Adds certain substances to the Uniformed Controlled Substance schedule.
• Senate Bill 773: Requires the Oklahoma Health Care Authority to request information for care coordination models for children in DHS custody.
• Senate Bill 816: Defines resident, as it relates to the Oklahoma Hospital Residency Training Program Act, as an individual who resided in this state at the time of graduation from an Oklahoma high school. The bill ensures medical students in this state who are in good academic standing will receive priority consideration for Oklahoma residencies.

2017 LEGISLATIVE SESSION: AT A GLANCE
2,462 bills filed
930 passed out of committee
607 bills passed to the opposite chamber
197 signed by the governor
17 vetoed

2017 BILLS PASSED, BY SUBJECT*
Regulatory: 119
Education: 53
Budget & Finance: 45
Health care: 38
Judicial: 32
Public Safety: 30
Human Services: 25
Agriculture: 20
Infrastructure, Veterans & Military Affairs: 19
Energy, Elections: 7
Tribal affairs: 2

*Source: Oklahoma Policy Institute

INTERIM STUDIES
Interim studies are an opportunity for legislators to highlight certain issues of special importance. These studies allow time for analysis and discussion on items that either failed to pass legislative hurdles or needed additional examination that a four-month legislative session doesn’t allow. All legislators may request interim studies, but they must receive approval from legislative leadership. Interim study subjects for the state house and state senate are below: (continues on pg. 30)
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HOUSE INTERIM STUDIES:
» IS 13: Current workers’ compensation reforms
» IS 26: Consolidation of state agencies
» IS 46: Controlling the cost of health insurance
» IS 58: Understanding revolving funds & utilization in budgeting process
» IS 70: Insurance reimbursement for athletic training healthcare services
» IS 77: Examining Medicaid cost in Oklahoma
» IS 93: Studies standardizing Alzheimer’s and dementia curriculum for CNA programs
» IS 115: Studies boards controlling trusts, commissions and unelected gubernatorial appointees
» IS 129: Challenges and successes in medically underserved communities

SENATE INTERIM STUDIES:
» IS 26-Studies licensure of midwives
» IS 27-Studies physician supervision of nurse practitioners
» IS 28-Studies balanced billing by out of network providers
» IS 29-Studies deaths and near deaths from oral surgery
» IS 30-Studies returning to a risk-based managed care model for Medicaid
» IS 31-Studies implementing a diabetes prevention program
» IS 32-Studies radiologic technologists
» IS 33-Examines best practices in preventing overdoses and suicide
» IS 34-Studies the cost of infertility treatments

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Consider a gift in your will or trust to the Oklahoma Educational Foundation for Osteopathic Medicine. For questions or to discuss further, call Lana Ivy at 800-522-8379.
OEFOM
CONTRIBUTIONS
June 1- August 31, 2017

Contributing
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John D. Tran, DO
John F. Rice, DO
Christopher V. Moses, DO
Harold L. Battenfield, DO
Sean C. Ludlow, DO
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M. Denise Speed, DO
David R. & Julie White, DO
Terry M. Lee, DO
Adam B. Smith, DO
Debra Montgomery, DO

Fund
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Building Maintenance Fund
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Student Activity Assistance Fund
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Student Activity Assistance Fund
Student Activity Assistance Fund
Scholarship Fund

OEFOM
MEMORIALS
June 1- August 31, 2017

Contributing
In Memory of
Thomas J. Carlile, DO
Edward Schaul
Thomas J. Carlile, DO
Charles Yon
Thomas J. Carlile, DO
Mary Jane Carrigan
Debra Montgomery, DO
Dr. Jimmy R. Herndon
Terry Nickels, DO
Mary Jane Carrigan
Joseph R. Schlecht, DO
AnnaBell Stevens Highland
Loretta Gonzalez
Tom Lovelace
Thomas J. Carlile, DO
Billy Ray Ryans, Jr.

Oklahoma D.O. | Fall 2017
Let’s Celebrate You

Help us wish these OOA members a Happy Birthday!

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<tr>
<th></th>
<th>Name</th>
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<td>1</td>
<td>Gerald R. Hale</td>
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<td>2</td>
<td>Jenny J. Alexopulos</td>
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November

December
The osteopathic profession continues to take the lead in combating the state’s opioid epidemic. Layne E. Subera, DO, was appointed by Oklahoma Attorney General Mike Hunter to a nine-member state commission on opioid abuse. In May, Dr. Subera was also appointed by OSU President V. Burns Hargis to serve a four-year term on the Oklahoma State University Center for Health Sciences College of Osteopathic Medicine Advisory Council. Dr. Subera served as OOA President in 2012-2013.

Bret S. Langerman, DO was selected by the Governor to serve on the Oklahoma State Board of Osteopathic Examiners. Dr. Langerman’s term ends in 2024. Dr. Langerman served as OOA President in 2013-2014.

Jonathan K. Bushman, DO, was recently appointed by the Governor to serve a three year term as the OOA representative on the Oklahoma Long Term Care Facility Advisory Board. The Board serves as a professional advisory body to the State Commissioner of Health. As part of its activities, the board advises the Oklahoma State Department of Health on the development and improvement of services as well as the care and treatment of residents in facilities subject to the provisions of the Nursing Home Care Act, homes subject to the provisions of the Residential Care Act, facilities subject to the Continuum of Care and Assisted Living Act, and facilities subject to the provisions of the Adult Day Care Act. Dr. Bushman currently serves as an OOA Board member.

Several Oklahomans were appointed to serve on AOA Committees for 2017-2018. They include:

- Heather N. Ivy, DO: AOA Board of Trustees (Resident Advisor), Bureau of Membership, Bureau of Emerging Leaders
- Ronnie B. Martin, DO: Bureau on Federal Health Programs, Joint Board/House Budget Review Committee
- Sherri Wise, CPA: Bureau on State Government Affairs, Bureau on Osteopathic Education
- Scott S. Cyrus, DO: Bureau on State Government Affairs
- C. Michael Ogle, DO: AOA Board of Trustees, Bureau on Osteopathic Education, Appeal Committee of the Bureau of Healthcare Facilities Accreditation, Bureau of International Osteopathic Medicine (Chair), Joint Board/House Budget Review Committee, Board Appeal Committee
- Joseph R. Schlecht, DO: Bureau on Socioeconomic Affairs
- David F. Hitzeman, DO: Bureau on Socioeconomic Affairs (Chair)
- Owais Durrani, OMS-IV: Bureau on Osteopathic Continuing Medical Education
- Jeffrey Stroup, PharmD: Committee on Osteopathic College Accreditation
- Kayse M. Shrum, DO: Bureau on Osteopathic Specialists
- Ray E. Stowers, DO: President’s Advisory Council
- Clayton H. Royder, DO: House of Delegates Committee on Ad Hoc

Do you have good news to share?

We would love to include it in our next edition of Oklahoma D.O.! Contact Maegan Dunn at 405-528-4848 or maegan@okosteo.org to submit your news today.
In Memorial: Deaths in the Osteopathic Family

Thomas A. Jones, DO, of Broken Bow, went to be with our Lord and Savior on July 25, 2017. Dr. Jones was a kind, down to earth, loving husband, father, and friend. He was a devoted doctor who cared for his patients as if they were family. He has impacted the lives of many and will be a greatly missed role model for the community. Dr. Jones was the kind of man young men hope to be when they grow up, and old men wish they had been. Our heart felt sympathies go out to Dr. Jones’s wife, Sherri, and the entire Jones family for this tremendous loss.

Beverly J. Mathis, DO, of Tulsa, slipped peacefully away surrounded by her family on September 2, 2017. Dr. Mathis had a passion unlike most in her field of choice. She truly loved medicine and teaching. Following in the footsteps of her late grandfather Dr. C.D. “Pop” Heasley, the first licensed osteopathic physician in Oklahoma, Dr. Mathis bravely advocated for her patients and the people whom she worked with for many years. Our thoughts and prayers are with Dr. Mathis’s husband, Frank, their two children, Molly and Andrew, and the entire Mathis family during this difficult time.

Calendar of Events

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| Oct. 4, 2017 | Bureau on Legislation  
Dinner 6:30 p.m., Meeting 7 p.m.  
Oklahoma City, OK |
| Oct. 5, 2017 | OOA Bureaus & Board of Trustees Meetings  
OSU-COM Advisory Council Meeting  
Oklahoma City, OK |
| Oct. 7-10, 2017 | OMED  
Philadelphia, PA |
| Dec. 7, 2017 | OOA Bureaus & Board of Trustees Meetings  
OSU-COM Advisory Council Meeting  
Oklahoma City, OK |
| Jan. 4, 2017 | OOA Bureaus & Board of Trustees Meetings  
OSU-COM Advisory Council Meeting  
Oklahoma City, OK |
Hard Rock Hotel  
Catoosa, OK |

In Memory Of...

Honor a deceased physician by making a memorial contribution to the Oklahoma Educational Foundation for Osteopathic Medicine.

An acknowledgment of your gift is sent to the family.  
No amounts are mentioned.

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